Washington State Health Care Authority

PRESCRIPTION FORM

This prescription is valid for one (1) year from date signed.

SECTION I	
PATIENT'S NAME	DATE OF BIRTH
DIAGNOSIS	
LENGTH OF NEED ☐ Indicate rental if applicable ☐ Less than 6 months ☐ Greater than 6 months ☐ Number of months _____	

SECTION II		
ITEM	QUANTITY	SUPPLIES – FREQUENCY OF USE

SECTION III			
PHYSICIAN'S PRINTED NAME	TELEPHONE NUMBER	FAX NUMBER	Physician NPI
PHYSICIAN'S ADDRESS		CITY	STATE ZIP CODE
I certify that I am the physician identified in Section III of this form and that the medical necessity information in Section I and II is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact in those sections may subject me to civil or criminal liability. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTED).			
PHYSICIAN'S SIGNATURE			DATE SIGNED